Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaine Tester, a prisoner at HMP Gartree, on 1 November 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Shaine Tester died from catastrophic haemorrhage after he made multiple cuts to his body on 1 November 2022 at HMP Gartree. He was 34 years old. I offer my condolences to Mr Tester's family and friends.

Mr Tester was a complex man who had regular thoughts of suicide and self-harm. Generally, he received efficient multi-disciplinary support from staff at Gartree. Staff ended suicide and self-harm prevention procedures a few days before he died. While it was not obvious that his risk of suicide had significantly increased before his death, some aspects of his mental health had not yet been assessed.

Staff who responded when Mr Tester was found on 1 November, tried hard to save him despite the extremely distressing circumstances.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. On 3 January 2022, Mr Shaine Tester was remanded to HMP Lewes charged with making threats to kill, possession of offensive weapons and assaulting police officers. He was later sentenced to 27 months imprisonment.

2. While at Lewes, Mr Tester spent extended time in the segregation unit as staff considered his risk of violence to others could not be managed on a standard wing. From June onwards, Mr Tester was supported through Prison Service suicide and self-harm monitoring procedures (known as ACCT). On 23 September, Mr Tester transferred to HMP Gartree.

3. Prison staff stopped ACCT procedures on 11 October, and after being briefly restarted, they were stopped again on 27 October.

4. At 1.35am on 1 November, the night orderly officer (the most senior officer on duty) found a voicemail message on the safer custody hotline from Mr Tester's mother that she had left several hours earlier asking for Mr Tester to telephone her. The night orderly officer asked a member of staff to check Mr Tester and she found him lying on his cell floor in a pool of blood. She radioed a medical emergency code.

5. The night orderly officer responded and found that Mr Tester had barricaded his cell door. Once the door was pushed open the nurse went into the cell followed by an officer, and they started cardiopulmonary resuscitation (CPR).

6. Paramedics arrived at 2.49am and at 2.53am, confirmed that Mr Tester had died.

Findings

7. Generally, Mr Tester received suitable multidisciplinary support from staff at Gartree. However, the prison lost a vital component of the ACCT plan that was closed a few days before he died, so we were not able to assess some of the decision making involved. As Mr Tester was refusing to take anti-psychotic medication and had not yet seen the psychiatrist, we consider that it would have been prudent to continue ACCT monitoring until this had happened.

8. The clinical reviewer concluded that the clinical care Mr Tester received at Gartree was partially equivalent to what he could have expected to receive in the community. Mr Tester did not receive an appropriate level of mental health care during his time at Gartree and a formal safety plan should have been devised to help manage him more effectively.

Recommendations

- The Head of Healthcare at Gartree should ensure that safety plans are written for all prisoners who have self-harmed.

- The Head of Healthcare at Lewes should ensure that a formal clinical handover is arranged for all complex mental health prisoners before transfer to a new prison.

The Investigation Process

9. HMPPS informed us of Mr Tester's death on 1 November 2022. The investigator issued notices to staff and prisoners at HMP Gartree, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Gartree on 15 November. He obtained copies of relevant extracts from Mr Tester's prison and medical records.

11. The investigator interviewed 13 members of staff at Gartree from 16 to 20 January 2023. He interviewed one other witness in March by video link.

12. NHS England commissioned a clinical reviewer to review Mr Tester's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with the clinical staff.

13. We informed HM Coroner for Rutland and North Leicestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Tester's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Tester's mother said the following:

    - She did not understand why her son had remained so long in the segregation unit at HMP Lewes.
    - She did not understand why her son was not on a list for the PIPE unit or personality disorder unit at Gartree as she had been led to believe that that was the reason for his move there.
    - She wanted to know why he remained so long on the induction unit at Gartree.
    - There was a four hour delay before staff acted on the message she left on Gartree's safer custody helpline on 31 October.
    - She received mixed messages about whether or not her son had left behind letters written just before his death.

15. Mr Tester's mother also asked about her son's medical care and these questions have been addressed in the clinical review.

16. We shared the initial report with Mr Tester's mother and HMPPS. HMPPS identified no factual inaccuracies.

17. Mr Tester's mother's solicitors raised a number of issues relating to our investigation which we have addressed in separate correspondence. We have also amended the wording in the penultimate paragraph of our foreword to say that Mr Tester had regular thoughts of suicide and self-harm rather than that such thoughts were quite normal for him.

Background Information

HMP Gartree

18. HMP Gartree, near Market Harborough in Leicestershire, holds up to 700 male prisoners mainly sentenced to life imprisonment and other indeterminate sentences. Nottinghamshire NHS Trust provides healthcare. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Gartree was in January 2023. In his introduction, the Chief Inspector wrote that Gartree was a well-led institution that generally provided good outcomes for those detained. Inspectors noted that Gartree now received long-term prisoners much earlier in their sentences and while the prison had risen to the challenge, there was still work to do to manage the expectations of prisoners who were understandably focused on meeting the objectives of their sentence plans as early as possible.

20. Inspectors also found that while ACCT processes had improved since the previous inspection, delivery was inconsistent in quality. In particular, care plans were weak, and issues raised in reviews were not always added to plans. Inspectors found that mental health services had improved since the previous inspection. They noted that twice-weekly multidisciplinary referral meetings provided oversight of the team's workload and ensured that patients received the most appropriate care. In addition, a daily duty worker attended all initial ACCT reviews.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2022, the IMB found that on the whole, prisoners at Gartree were treated fairly and humanely and that relationships between prisoners and staff were generally positive. The IMB noted that there had been a ten percent increase in the recorded incidents of self-harm compared to the previous reporting year and that 27 of the 242 incidents, were classed as serious 'near-miss' incidents.

Previous deaths at HMP Gartree

22. Mr Tester was the 17th prisoner to die at Gartree since April 2019. Of the previous deaths, four were self-inflicted and 12 were from natural causes. In a death of a prisoner at Gartree in September 2021, we found deficiencies in the management of the prisoner's ACCT plan, but the deficiencies were different to those we identified in Mr Tester's case. There were no other similarities between this investigation and the previous deaths.

Assessment, Care in Custody and Teamwork

23. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care plan to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychologically Informed Planned Environment

24. Psychologically Informed Planned Environments (PIPEs) form a key part of the Prison Service's offender management strategy. PIPEs are specifically designed living areas where staff trained in psychological understanding aim to create a supportive environment that can facilitate the development of prisoners with challenging behavioural needs. PIPEs are not a treatment intervention, instead they are designed for those who have recently completed high intensity offending behaviour and treatment programmes and aim to enable progress through the maintenance and development of previously achieved learning.

Offender Personality Disorder Pathway

25. The Offender Personality Disorder (OPD) pathway programme is a jointly commissioned initiative between NHS England and Improvement and HM Prison and Probation Service. The pathway is aimed at supporting and managing high-risk high-harm offenders with complex mental health needs. The need for offenders to access appropriate services is a key principle of the pathway with offender managers having a key role in the early identification of an individual's needs and the identification of appropriate intervention programmes.

Key Events

26. On 25 September 2005, Mr Tester was arrested and charged with attempted robbery, possession of an offensive weapon and common assault. He was 17 years old. Mr Tester was later convicted and sentenced to an indeterminate sentence for public protection (IPP) and received a minimum term of 18 months.

27. By July 2014, Mr Tester had moved to an open prison. On 9 July, Mr Tester absconded with another prisoner: this was the second time that he had absconded from an open prison. The next day, Mr Tester was arrested and charged with a further offence of robbery and possession of an offensive weapon. He was sentenced to a further term of four years and six months.

28. In August 2016, Mr Tester was moved to a medium secure mental health hospital where he remained for four months before returning to prison. He went back to the mental health hospital in June 2017, and this time he remained there until August 2020, when he was released back into the community. Mr Tester had been diagnosed with dissocial personality disorder with schizoid and paranoid traits. He also had periods of high anxiety and recurrent depression. There were conflicting views from professionals about whether Mr Tester had other possible diagnoses for other conditions, including schizophrenia.

29. On 1 January 2022, Mr Tester was arrested for making threats to kill, possession of offensive weapons and for assaulting police officers. He was remanded to HMP Lewes on 3 January and was later sentenced to 27 months in prison. In addition to this new sentence, Mr Tester was still subject to his original IPP sentence.

30. On 15 June, Mr Tester smashed his television and used a plastic shard to make several deep cuts to his wrists, arms and torso. His medical record noted that he also tied a ligature to a shower fitting in his cell, but the fitting broke and came away from the wall. As Mr Tester was behaving violently, officers placed him under restraint so they could move him to a different cell. Nurses cleaned and treated his wounds. Mr Tester was taken to hospital and was sedated due to his agitation. Staff started ACCT procedures. (Mr Tester had been supported through ACCT on many previous occasions while in prison, usually following incidents of minor self-harm.)

31. On 19 June, Lewes submitted a request to the Prison Service's long term high security estate (LTHSE) population management team to request that Mr Tester be transferred to a new prison. In the referral, Lewes explained that in his six months at the prison, he had stayed either in the healthcare unit or the segregation unit. They explained that moving him to a standard prison wing had not been an option as he refused to take his prescribed anti-psychotic medication, which meant that his behaviour was unpredictable and his propensity for violence was a risk that could not be managed on a standard wing. Lewes wrote that it was not equipped to deal with Mr Tester's needs. Lewes also explained that Mr Tester and his legal team had been trying to pursue a hospital order (which would allow him to transfer to a mental health hospital), but all avenues had been exhausted and he had been told that he would be spending his sentence in prison.

32. Mr Tester returned from hospital to Lewes on 27 June and was placed under constant observation in the healthcare unit. At an ACCT assessment interview, Mr Tester said that the incident of self-harm had been "a moment of madness".

33. At an interview with his key-work officer on 30 June, Mr Tester said that he did not want to harm himself and he was scared that he had almost killed himself. He said that he was frustrated because he could not get the mental health treatment he needed in prison and wanted to go back to hospital.

34. On 12 July, Mr Tester was moved to the segregation unit where he continued to remain under constant observation. The psychiatrist at Lewes noted his agreement with a senior prison manager that the segregation unit was "the best and safest place to manage [Mr Tester's] likely increase in risk to [himself] and others …"

35. At an ACCT review on 14 July, Mr Tester asked if he could move to Lewes' healthcare unit (he felt that he needed to be in a mental health setting and preferred smaller units). Staff at the review meeting told him that he was not suitable to move to the healthcare unit or a mental health unit, instead Lewes was seeking to transfer him to another prison that could meet his needs. A note was added for staff to continue to speak to Mr Tester about a move to a prison with a psychologically informed planned environment unit (PIPE unit).

36. Following receipt of the request from Lewes, the LTHSE approached HMP Gartree about taking Mr Tester. Gartree's Deputy Governor asked the prison's Head of Psychology if Mr Tester was suitable for Gartree. The Heald of Psychology told the investigator that while Mr Tester met some of the criteria for Gartree's PIPE unit, there were other criteria he did not meet: in particular, that he had not engaged in medium to high intensity treatment in the last two years. However, she considered that he would be suitable for a place within the prison's general therapeutic community where he would undertake the Kaizen high risk violence programme. She said that if Mr Tester had completed Kaizen, or whatever other treatment was identified to reduce his risk of re-offending, that he might in due course have moved to Gartree's progression PIPE unit.

37. The Head of Psychology said that a video conference was arranged for Mr Tester to speak to her and other staff at Gartree to discuss his transfer. She said that this was not something that Gartree normally did, but she recognised that the move would be difficult for him.

38. The video conference between Gartree and Lewes was arranged for 16 September, but, on the day, Mr Tester refused to attend. An officer at Lewes noted that it was disappointing that Mr Tester had not taken part as he had spoken with him about it a number of times and that Mr Tester had said that he would attend. The officer told Mr Tester that his failure to attend the conference would not change the fact that he would be transferring to Gartree.

39. Mr Tester's last ACCT review at Lewes was on 22 September. Mr Tester said that he was "good" and that he had no intention of harming himself. He said, however, that he did not want to go to Gartree. His ACCT observations were increased to one an hour as a precaution ahead of his transfer. (For the previous four weeks, Mr Tester's observations had been set at three during the day and three at night.)

40. On 23 September, Mr Tester transferred from Lewes to Gartree.

HMP Gartree

41. When he arrived, he saw a nurse for a reception health screen. The nurse noted that Mr Tester had a history of self-harm, but that he was settled in mood that day and had no current thoughts of self-harm.

42. Mr Tester was moved to G wing where a Custodial Manager (CM), a Supervising Officer (SO) and a mental health nurse saw him for an ACCT review. Mr Tester said that he did not intend to take his life but said that his parole review was due within the next four months, so he did not understand why he had been transferred to Gartree. The review team set Mr Tester's observations to three an hour with two conversations a day.

43. The nurse told the investigator that, at times, Mr Tester would look at the ceiling while talking, but he was able to concentrate, his speech was normal in rate, rhythm and tone and there was no evidence of delusionary beliefs.

44. On 24 September, Mr Tester had a follow-up health screen. The nurse noted that Mr Tester had enduring mental health problems and a history of self-harm, and she referred him for assessment by the mental health team.

45. On 27 September, an SO chaired Mr Tester's next ACCT review. Mr Tester said that he was "okay", but that he did not understand why he had moved to Gartree as he had no family nearby. He also said that he should have been sent to a mental health unit as he had paranoia and schizophrenia. The SO noted that Mr Tester was very restless: Mr Tester said that if he did not keep some part of his body moving, he would struggle to concentrate and would "zone out". The SO asked Mr Tester if he had any thoughts of suicide or self-harm and Mr Tester said that he had never been truly suicidal and that he did not want to die. Mr Tester agreed with the SO's suggestions to reduce the observations to two an hour.

46. Mr Tester's next ACCT review was on 29 September, and was chaired by SO A, who had been appointed as Mr Tester's ACCT case manager. Another SO and a nurse also attended the review. SO A said that Mr Tester engaged well at the review and spoke openly and eloquently. He said, however, that he did not like being in a large prison wing so would prefer to move to a small unit, such as the segregation unit, or move to a hospital. He also said that he was too far from home. SO A reduced Mr Tester's observations to one an hour.

47. Ahead of the review, a member of the psychology team emailed SO A to say that Mr Tester had been discussed at the safety intervention meeting (a multi-agency forum to discuss complex prisoners) when she asked if any intervention from psychology would be helpful. She told SO A that she was not available to attend the ACCT review that day but asked him if he wanted any general input from psychology or wanted anyone from psychology to attend Mr Tester's next ACCT review. The psychology team member told the investigator that she did not receive a reply to her email.

48. On 30 September, a nurse saw Mr Tester for a mental health assessment. The nurse noted that Mr Tester had diagnoses of antisocial personality disorder,

schizoid type personality and narcissistic personality disorder. He noted that Mr Tester said that he had once been in receipt of aripiprazole (used to treat the symptoms of schizophrenia), but he would not accept this medicine again unless he was sent back to a mental health hospital or sent back to Lewes. He noted that Mr Tester would be discussed at the next mental health allocations and discharge meeting.

49. Mr Tester's next ACCT review was on 4 October. SO A was not on duty so another SO chaired the review. A nurse also attended. The SO noted that Mr Tester had not harmed himself since being at Gartree, nor had he had any such thoughts. He noted that Mr Tester was eating his meals and taking showers. He also noted that, long term, Mr Tester was hoping to move closer to his family near Brighton, and preferably to a hospital. He further reduced Mr Tester's observations to one every two hours.

50. On 6 October, Mr Tester was discussed at the mental health allocations and discharge meeting. A nurse noted that Mr Tester was not suitable for the mental health caseload, but he would be added for discussion at the psychiatrist's next multidisciplinary team meeting.

51. SO A chaired Mr Tester's next ACCT review on 11 October and was accompanied by another SO and a nurse. SO A noted that Mr Tester constantly tapped his feet and was also making physical motions with his arms and hands. Mr Tester again said that he coped better in small units or in special hospitals. He also said that he had no present thoughts of self-harm and was fairly settled, provided he was left alone. Mr Tester also spoke about his upcoming parole review and the potential outcome from that. SO A closed the ACCT given Mr Tester's positive attitude.

52. On 12 October, Mr Tester was discussed at the psychiatrist's multi-disciplinary team meeting. It was noted that there were conflicting views whether Mr Tester had schizophrenia and that some clarity was needed. Mr Tester had been due to see the psychiatrist on 26 October, but on 12 October the appointment was rearranged for 16 November.

53. On 15 October, Mr Tester tested positive for COVID-19 and was told that he would have to isolate from other prisoners for the next seven days. Mr Tester accepted paracetamol for pain related to COVID-19 symptoms (this was the only medication Mr Tester received at Gartree).

54. Mr Tester had a post-closure ACCT review on 20 October and said that he was worried that he might kill himself. Staff started ACCT procedures again.

55. SO A chaired an ACCT review on 23 October and was accompanied by a general nurse. As Mr Tester was still in isolation, the review took place at his cell door. Mr Tester said that he found it difficult having to remain in his cell. He acknowledged that he had made a comment about killing himself but said that this was a regular thought for him and that he had no plans on acting on those thoughts at present. SO A noted that he would chair another ACCT review on 27 October, by which time Mr Tester should be testing negative for COVID-19. On 26 October, Mr Tester provided a second negative COVID-19 test and was no longer required to isolate.

56. SO A chaired Mr Tester's next ACCT review on 27 October and was accompanied by a mental health nurse. SO A noted that Mr Tester engaged well at the review. Mr Tester said that he had been frustrated during the period when he had COVID-19 and had to remain in his cell and that was why he had made the comment about harming himself. SO A told Mr Tester that he would not be moving to I wing (a small specialist unit that Mr Tester had asked about), but Mr Tester said that he was happy to remain on G wing. SO A reminded Mr Tester that he had a meeting scheduled with his probation officer in two weeks' time and noted that this put him in a positive mood. He noted that all at the review were content that ACCT monitoring should stop.

57. SO A told the investigator that the review on 27 October had been "a really good review" and he had no concerns for Mr Tester's safety. He also explained that I wing was for prisoners who struggled on other wings including those who were regularly in debt. He said that Mr Tester did not fit the criteria for I wing at that time.

58. The general nurse noted that Mr Tester presented as quite unkempt, but this was normal for him, and his speech was spontaneous and coherent with no paranoid delusional ideas and no deficit in perception. She told the investigator that there was nothing about Mr Tester's behaviour to suggest he intended to harm himself.

59. On 31 October, an Operational Support Grade (OSG) started a night shift at 8.00pm. She had not previously met Mr Tester, but she noted that he rang his cell bell three times that evening. The first time was to ask for some envelopes and the second time was to hand her a sheet of paper with some writing, which she subsequently gave to the police. She reminded Mr Tester that the cell bell was for emergencies, and she asked him if he needed anything. Mr Tester responded by apologising several times. The third time he rang the bell, the OSG noted that he appeared to be swaying back and forth and said several times words to the effect of "tell them that I corrected it". She reminded Mr Tester that the cell bell was for emergencies only and that he did not need anything. He again apologised. The OSG said that she spoke to an officer, and he told her not to worry as that was not unusual behaviour for Mr Tester.

60. The investigator listened to three telephone calls that Mr Tester made from his in-cell phone to his partner and brother that evening. In the first two calls, one to his partner and one to his brother, Mr Tester made a number of strange comments, such as referring to a woman in a shed over the road from his window who kept on screaming. Neither his partner nor his brother appeared overly concerned at the comments. Mr Tester's final call was a two minute call to his brother at 7.34pm. They spoke about nothing in particular and there was nothing of obvious concern about Mr Tester's presentation.

Events of 1 November

61. On 1 November, a Custodial Manager (CM) who was the night orderly officer (the most senior officer on duty) that night, told the investigator that the prison has an at risk helpline which is checked by the orderly officer three times a day: in the morning, at midday and in the early evening. He said that at around 1.35am, he noticed that there was no record that the helpline had been checked the previous evening before the day-time orderly officer finished his shift. He checked for

messages and found that Mr Tester's mother had left a message at 9.34pm. She said that her telephone that had been out of order but was then working again and she wanted her son to contact her as she had not heard from him for a while. The night orderly officer asked the OSG to check if Mr Tester was awake and if he was, to pass him the message from his mother.

62. The OSG went to Mr Tester's cell and, when she looked through the observation hatch, she saw him lying on his cell floor with a lot of blood on his body and smeared around the cell. She radioed a medical emergency code blue (to indicate a prisoner is unconscious or having breathing difficulties). She said she realised she should have radioed an emergency code red but made a mistake due to distress at the sight. Communications staff noted that the call was received at 1.48am and they called an emergency ambulance. She was carrying a cell key in a sealed pouch (which is the standard procedure at night time). She said that she tried to open the pouch, but she could not break the seal.

63. A nurse was in the healthcare unit when she heard the code blue call. She called over the radio to ask if the patient was breathing and she was told only that there was a lot of blood. She said that she left the healthcare unit with the emergency bag for both code blue and code red emergencies and an officer, who was also responding, took one of the bags for her.

64. The nurse and a number of officers arrived at Mr Tester's cell at the same time and around three minutes after the code blue call. The night orderly officer unlocked the door but found that Mr Tester had created a barricade with his mattress and cupboard. The night orderly officer was able to push open the door slightly and he asked the nurse to squeeze through the gap and to remove the barricade. Once she had done that, the nurse checked Mr Tester and saw that he had significant lacerations to his neck and abdomen. She noted that he was not breathing, that he had no pulse and that his eyes were open and fixed. She also noted that while his hands and arms were cold to the touch, there were no signs of cyanosis (when the skin turns blue due to lack of oxygen). As she began taking equipment from the emergency bags, she asked an officer to start cardio-pulmonary resuscitation (CPR). Staff took turns in giving CPR and the nurse gave oxygen and checked Mr Tester with a defibrillator, which advised that no shock could be given, and that CPR should continue. Staff took turns in giving further CPR.

65. Ambulance paramedics arrived at 2.49am. They noted that CPR had been going on for an hour without success and at 2.53am, they confirmed that Mr Tester had died.

Contact with Mr Tester's family

66. A family liaison officer (FLO) was appointed. Due to the distance to Mr Tester's mother's home, the prison asked local police to visit her to break the news of her son's death. She was told the news at 10.50am and the FLO followed-up with a telephone call at 2.05pm.

67. Gartree contributed to the cost of Mr Tester's funeral in line with national instructions.

Support for prisoners and staff

68. After Mr Tester's death, Gartree's deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

69. The prison posted notices informing other prisoners of Mr Tester's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Tester's death.

Post-mortem report

70. The pathologist gave Mr Tester's cause of death as catastrophic haemorrhage from multiple self-inflicted cuts. The post-mortem report noted that he had multiple cuts to his neck as well as a deep cut to his abdomen. He also had cuts to his legs and the pathologist noted multiple scarring from old cuts. Toxicological examination detected no significant findings.

Events following Mr Tester's death

71. In addition to the sheet of paper that Mr Tester gave to the OSG, various other sheets of paper were found in his cell following his death. Much of what he wrote suggested unusual thinking, but he did not make any comment about thoughts to take his life. These sheets of paper had caused Mr Tester's mother to believe he might have left behind letters.

72. Two pieces of plastic were found in Mr Tester's cell. One was a piece of blue plastic broken from a dustpan and the other was clear plastic from an unknown source. Police investigators believed that it was one or both of these that he used to make the cuts as no other sharp items were found.

Findings

Assessment of Mr Tester's risk of suicide and self-harm

73. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, states that ACCT case review teams must be multi-disciplinary where possible. It advises that the ACCT process will operate more effectively if there is continuity in the attendance of staff from relevant departments and services so every effort should be made to ensure the same members of staff attend the reviews, including input from healthcare staff.

74. Mr Tester had a history of self-harm and had been supported through ACCT monitoring at various times while in prison custody, and during his time at Lewes, he had been supported constantly on ACCT monitoring from 15 June until his transfer to Gartree on 23 September.

75. Staff at Gartree were aware that Mr Tester wanted to move to a mental health hospital and wanted to move back closer to his family. In addition, staff were aware that he had an extensive history of mental illness, that he had refused anti-psychotic medication and that he was still waiting to see a psychiatrist. Although Mr Tester made no explicit comment about plans to kill himself while at Gartree, he said that thoughts of harming or killing himself were regular for him.

76. The majority of Mr Tester's ACCT reviews at Gartree were multidisciplinary with consistent case management by SO A and good attendance by general and mental health nurses. Disappointingly, Gartree lost Mr Tester's ACCT care plan, so the investigator was not able to assess the adequacy of the plans drawn up to identify and address Mr Tester's most urgent needs, nor assess whether all of the care plan actions had been completed when ACCT procedures were stopped.

77. While it certainly does not follow that all prisoners with mental health problems are at risk of harming themselves, this had been a risk for Mr Tester in the past and, given his other risks, including that he was not taking medication and had not yet seen the psychiatrist, we consider it would have been prudent to keep ACCT monitoring in place until staff had more information about Mr Tester's complex mental health and personality disorders. The Governor will wish to consider the learning from this investigation.

Clinical care

78. The clinical reviewer concluded that Mr Tester's care at Gartree was partially equivalent to what he could have expected to receive in the community. She noted that there was no formal handover of care from Lewes to Gartree, which would have been happened between community services to ensure continuity and comparable levels of mental health care. She noted that when Mr Tester was at Lewes, he was on the mental health team's caseload and was seen at least weekly and she would have expected a comparable level of mental health care at Gartree, even if this was just for short term support while he was awaiting assessment by the psychiatrist at the prison.

79. The clinical reviewer noted that the psychology team at Gartree, who were aware of Mr Tester, had offered to attend his ACCT reviews, but they were not invited to attend.

80. The clinical reviewer also referred to new guidance published in September 2022 by the National Institute for Health and Care Excellence (NICE) which discusses the use of a safety plan for the management of people who have self-harmed. She considered that creating a safety plan would have provided a more structured and evidence-based intervention for Mr Tester and could have been utilised by him, his family and by prison and healthcare staff. We recommend:

    The Head of Healthcare at Gartree should ensure that safety plans are written for all prisoners who have self-harmed.

    The Head of Healthcare at Lewes should ensure that a formal clinical handover is arranged for all complex mental health prisoners before transfer to a new prison.

81. The clinical reviewer made some recommendations about asking prisoners about thoughts of suicide and self-harm during the reception screen and about record keeping, which we do not repeat here, but which the Head of Healthcare will need to address.

Governor to note

Good practice

82. We commend the staff involved in the response for their concerted efforts to try to save Mr Tester's life in what were clearly both highly unusual and extremely harrowing circumstances.

At-risk hotline

83. Gartree's website has a link for support for family and friends and a section about the prison's safer custody hotline where family or friends can leave a message if they have concerns about the safety or wellbeing of a prisoner. The telephone number given then has a standard message to say: *"At-risk hotline at extension 6886 cannot be reached. You may leave a message or transfer to another extension. To leave a message begin speaking at the tone …".* The hotline always diverts to the message bank and there is no option to speak directly to a member of staff instead, no matter the time of day.

84. Mr Tester's mother left a message on the at-risk hotline at 9.34pm, that the night orderly officer found at 1.35am.

85. In normal circumstances, the at-risk hotline would have been checked by the orderly officer at around 7.00pm, and Mr Tester's mother's message would not have been discovered until around 7.30am on 1 November.

86. Although the at-risk hotline might have some purpose in the case of non-urgent concerns, it clearly has no value where a family member has immediate concerns,

which is not made clear in the recorded message. While it seems that Mr Tester's mother's contact with Gartree was to pass on a message rather than to raise an urgent concern, we invite the Governor to consider whether the at-risk hotline is fit for purpose.

Inquest

87. On 28 June 2024 an inquest into Mr Tester's death noted that his medical cause of death concluded that his cause of death was catastrophic haemorrhage from multiple self-inflicted cuts to the body and that on balance of probability, he intended to take his own life in an act of suicide.

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